

South Carolina Workers' Compensation Commission

1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675



WCC File #: _____

Carrier File #: _____

Carrier Code #: _____

Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ - - Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: () - Work Phone: () - Carrier: _____

Type of Occupational Disease: _____ Date/Period: _____

Preparer's Name: _____ Preparer's Phone #: () -

Occupational Disease Waiver

The undersigned applicant does hereby waive my right to make a claim for compensation for the occupational disease indicated while employed by the above employer. I understand my right to waive liability for the above-named disease as provided for in Section 42-11-80 and Regulation 67-1002 of the South Carolina Workers' Compensation Law, which reads in part:

"If an employee who had previously suffered from an occupational disease desires to continue in an employment to which such a disease is a hazard, he may waive his right to receive further benefits for disablement or disability from such disease by written agreement approved by the Commission in accordance with such rules as it may promulgate."

Therefore, it is my understanding that I only waive my right to receive compensation for the above-named disease and still retain all other rights given an employee under the South Carolina Workers' Compensation Law.

Applicant Name_____
Applicant Signature/Date_____
Employee's Legal Representative Name_____
Signature of Claimant or Legal Representative/Date_____
Witness Name_____
Witness Signature/Date_____
Approving Commissioner's Name_____
Signature of Approving Commissioner/Date

Employee's representative must complete and file Form 65 and physician's statement (per R.67-1002) with the Judicial Department.